READING HEALTH AND WELLBEING BOARD

Date of Meeting	17 January 2025
Title	Community Wellness Outreach Project Update
Purpose of the report	To note the report for information
Report author	Beverley Nicholson
Job title	Integration Programme Manager
Organisation	Reading Borough Council / BOB Integrated Care Board
Recommendations	1. That the board note the progress made in the Community Wellness Outreach project

1. Executive Summary

1.1. This report is being brought to Reading Health and Wellbeing Board to provide an update on progress made by the Community Wellness Outreach Project.

1.2. The Integrated Care Board have received funding from the Prevention and Inequalities fund, part of which was passported to Reading Borough Council, through the Integration Board, to set up a Community Wellness Outreach project that encompasses the NHS Health Checks as a core service and offering wrap around support from Voluntary and Community sector parties to provide a holistic support offer. This pilot project will run until the end of June 2025. There is a target to complete 5,200 NHS Health Checks within the project period, with particular emphasis on identifying those at risk of cardiovascular disease.

1.3. This report summarises the progress made up to the end of November 2024. The team are continuing to work with our Community partners to ensure an appropriate reach. The clinics are now operating on a dual option of drop in or book online model (in some cases venues have a 25% drop in and 75% booked arrangement), and more capacity has been provided by recruiting additional nursing staff delivering the checks at some of the venues, where there is space to do this.

2. Policy Context

2.1. This project aligns with several key objectives from the Council's Corporate Plan.

2.2. Firstly, the project demonstrates 'Collaborating with others', in particular that we are stronger in partnership and we collaborate with organisations from major corporations to local groups; with the business sector, charities, education institutions, health and social care, the police, faith groups, and the voluntary sector in Reading and across the Thames Valley to achieve our vision for Reading.

2.3. Secondly, the project contributes to the objective of achieving a 'Healthy Environment'. Our Health and Wellbeing Strategy aims to reduce the differences in health between different groups of residents and support those who are at high risk of poor health outcomes. This is exactly the aim of the Community Wellness Outreach project. The programme is focusing on reaching the Core20 Plus5 population groups i.e. those in deprivation deciles 1 to 4, alongside people from priority groups such as homeless/rough sleepers, carers, people from ethnically diverse groups, where we know there are higher risks of developing heart disease and diabetes, who have not had contact with their GP for some time.

2.4. Thirdly, the project supports an aim of 'Thriving Communities': Committed to tackling inequality in our society, to ensure everyone has an equal chance to thrive wherever they live and whatever their economic, social, cultural, ethnic or religious background.

3. The Proposal

3.1. The Programme was built on an existing model of mini-Health Checks that were being delivered within the Community as there were already links with community providers within the areas we wished to reach, e.g. Whitley and Church Wards. We now have several sessions running in different locations across Reading in order to enable access to the Health Checks, including the Atrium, Acre, Whitley Community Development Association, Southcote, and Coley Park. Working with the Royal Berkshire Hospital Meet PEET (Patient Engagement and Experience Team) service and Reading Voluntary Action (RVA) as the key delivery partners for the outreach NHS Health Checks, being delivered in community settings, and the wrap around support services for wellbeing to which people could be referred or to discuss issues impacting their overall wellbeing on the day with the Social Prescribing Team and Community Volunteer groups.

3.2. This is a pilot programme, which will run to the end of June 2025, to primarily increase the number of NHS Health Checks delivered for people in Reading, and focused in areas where we are more likely to reach cohorts of people who may be more disadvantaged e.g. may include (but not exclusively so): rough sleepers, socially isolated, military veterans; substance users; refugees and asylum seekers; those in financial hardship; not registered with a GP; ex-prisoners; ethnically diverse groups and Unpaid Carers).

3.3. The usual age group for eligibility for the NHS Health Check is 40 to 74 but this pilot will open the offer up to all people over the age of 18 in Reading with an aim of early identification of health or welfare conditions that could potentially cause poor health or wellbeing outcomes and working with that person to address these and support them to achieve their health and wellbeing goals.

3.4. As at 30th November there had been 2,214 people seen (42% of our target). There had been an initial soft launch of the programme and scaling up in the third phase to ensure we were able to meet the demand.

3.5. The outcomes for the cohorts seen so far are that 23% had high or very high blood pressure readings, 67% had high or very high BMI, 25% had high blood glucose readings and 7% had high cholesterol. Follow up action was recommended, including referral back to their GP for health related issues identified in the health check process, and social prescribing for weight management and smoking cessation, as well as mental health support. The ethnicity breakdown of people attending was 38% White, 39% Asian/Asian British, 15% Black, African, Caribbean or Black British and 5% other ethnically diverse groups. People seen to date have spanned 22 GP surgeries in Reading and 14 people have been supported to register with a GP since the start of the project.

3.6. Of those seen, 38% were outside the usual age range of people eligible to receive the Universal Health Checks (40 to 74), 8% above 74 and 30% below 40, ensuring a wider reach and more likelihood of picking up early indicators that impact on health and wellbeing outcomes. The number of checks carried out for those within the age range of 40 to 74yrs is being included in the nationally reported health check data via our Public Health Team.

3.7. We are working with primary care partners and "point of care testing equipment" providers to enable the flow of the Health Check information back into the GP records as an automatic uploaded directly to the care records following the checks. There have been some delays in this due to reconciling SNOMED Code lists to ensure the right coding but the process has now started and testing has been successful. The bulk upload of records will commence once the tests have been completed with all the GPs who have patients who have been seen for their health check at one of the community venues. We are keen that the outputs from this collaborative approach are impactful for all our key partners, and ultimately benefit our residents, with a focus on early intervention and prevention.

3.8. **Case Studies and Feedback:**

- *A Pakistani female was provided with further support and has since joined the active exercise class provided by Cumberland Road Mosque. She also called for support when speaking to the receptionist at her GP surgery and an appointment was made with the receptionist by RVA on her behalf.*
- *A non- English speaker had his check and needed to be referred to Social prescribing. He was sure he was registered with a GP but was unable to remember which practice he was registered with. RVA worked with different agencies to find out his GP practice so that he could be referred to them and supported by a Social prescriber.*
- *We also had someone who was referred to CWO via their case worker, on talking to them it was discovered they had had the check 3 months ago but needed an appointment as they had been suffering from temporary blackouts. The person was homeless, vulnerable and found it difficult to understand the health system. The team worked with staff at his surgery to organise an appointment which he attended and is now being followed up accordingly.*
- *An ex-military veteran needed an on the day appointment following their Health Check. The community leader, RVA and Meet PEET worked together to make a GP appointment that day. The community leader was able to report that the person had attended their appointment and were being monitored for the reason that had been brought up in the check.*
- *Calm, serene, peaceful, harmonious vibe and atmosphere the moment you step inside the venue.*
- *Great initiative! I had the best healthcare appointment in the last 10 years. Everybody very patient and explanation received on my understanding.*
- *This is an exceptional example of taking services to the communities you serve! Very easy to sign up to; very lovely staff. Quick checks done and you go with your result. Thank you, NHS and RVA. Well done to all involved!*

4. Contribution to Reading's Health and Wellbeing Strategic Aims

4.1. The desires outcomes of the project are very much in line with the overall direction of the Berkshire West Joint Health & Wellbeing Strategy 2021-30 by contributing to the following priorities (in bold):

1. **Reduce the differences in health between different groups of people**
2. **Support individuals at high risk of bad health outcomes to live healthy lives**
3. Help children and families in early years
4. Promote good mental health and wellbeing for all children and young people
5. **Promote good mental health and wellbeing for all adults**

4.2. The project aims to reduce the differences in health between different group of people and support individuals at high risk of bad health outcomes by targeting those who may not be accessing their GP and therefore are not accessing an NHS Health Check. By not engaging with their GP, these groups are at higher risk of complications from medical conditions (such as cardiovascular disease) that could have been identified earlier. By offering the health check in a community setting where they feel comfortable, this difference can be reduced.

4.3. Through the wrap around service provided by the Voluntary Sector and the Social Prescribers this project will also promote good mental health and wellbeing for all adults (as Reading is extending the offer of a health check and onward support to people from the age of 18).

5. Environmental and Climate Implications

5.1. There are no environmental of climate implications arising from this project as sessions will continue to be facilitated in community venues that are already active, often linked to other activities taking place within the centres and close to public transport.

6. Community Engagement

6.1. We worked with our Voluntary and Community sector, Primary and Secondary Care Health providers, Public Health Community Champions and Academic services to develop the pilot programme, including the Communications Plan, Training, Monitoring and Evaluation and reporting. There has been effective collaboration and engagement and a shared vision for this new way of working. The Meet PEET nurses from the Royal Berkshire Foundation Trust (RBFT) and Reading Voluntary Action (RVA) co-ordinator received Grass Roots Communities Awards in October 2024, for "Community education" and "Empowering communities through education for health and wellbeing", and the project team are proud to have supported a collaborative programme across health, social care and voluntary and community sectors. Healthwatch and the Community Health Champions were honoured in this category as well.

"Individuals dedicated to advancing educational opportunities within the community. Honourees demonstrate exceptional commitment to improving access to learning, fostering education equity, and empowering individuals through knowledge and skill-building."

6.2. Where appropriate we have also worked in conjunction with neighbouring Local Authority services in West Berkshire and Wokingham to ensure the approach was aligned across the Berkshire West Place. Whilst there are some variances in the delivery model, which will enable evaluation of the effectiveness in each locality, there has been a shared approach in respect of clinical and digital pathways, and key performance reporting to ensure consistency.

7. Equality Implications

7.1. An Equality Impact Assessment was started and the outcome was that a full assessment was not required, the reasons are set out below:

7.2. This programme will not have any differential impact on people with protected characteristics. The aim of the programme is to reach people who may be disadvantaged due to a number of factors impacting on their ability to access health and wellbeing services within their locality. By delivering the health checks and other wellbeing support within the community settings that they are more likely to attend, as well as targeting those that may be more at risk of poor health outcomes, we are aiming to address inequalities and ensure equity of service and support for all adults in Reading.

8. Other Relevant Considerations

8.1. The proposals for the project were scrutinised through the Reading Integration Board and Procurement and Legal services.

8.2. Officer Decision Notices were completed, and a briefing provided to Councillors.

9. Legal Implications

9.1. Procurement of services was through direct award under Regulations 12 and 72 of the Procurement Regulations and the subsequent Memorandums of Understanding and Deeds of Variation have been agreed in alignment with current policy.

9.2. Guidance was provided by Legal Services and the Procurement Hub at the Council.

10. Financial Implications

10.1. Funding for this scheme is via the Prevention and Inequalities Fund. Reading Borough Council have been allocated £811k by the Integrated Care Board to deliver this community outreach programme up to the end of June 2025. The programme aims to deliver 5,200 Health Checks as well as the wrap around wellbeing support, training and evaluation.

10.2. Confirmation of funding has been received from the Integrated Care Board via a Letter of Intent setting out the funding and the payment schedule. Invoicing has commenced and funding received to enable the onward funding support to our core health and community partners.

10.3. Governance of the funding and monitoring of spend against the plan has been incorporated into the Section 75 Framework Agreement 2023/24, for the Better Care Fund, grant funding as the funding for this programme will operate within the same governance structure.

11. Timetable for Implementation

11.1. The programme has taken a phased approach:

Phase 1: Aug – Sep 2023 – Preparing for upscale. **Complete**
Phase 2: Oct 2023 – Dec 2023 (Q3 23/24) – Initial upscale. **Complete**
Phase 3: Jan 2024 – Mar 2024 (Q4 23/24) – Building momentum. **Complete**
Phase 4: Jul 2024 – Dec 2024 (Q1-Q3 24/25) – Fully Established. **Complete**
Phase 5: Jan 2025 – Jun 2025 (Q4 24/25 - Q1 25/26) – Final phase of pilot. **In progress.**

11.2. Sessions are currently being delivered and an overview of what to expect, alongside the timetable of events, is available via the RVA Web pages set up for this pilot programme: Posters and leaflets include a QR code linking to the web pages, along with a telephone number for anyone wishing to speak with someone to find out more information.

Info and clinic list: https://rva.org.uk/community-wellness-outreach/

Details of the health check: https://rva.org.uk/nhs-health-check/

Calendar of the clinics: https://rva.org.uk/health-checks-grid-calendar/

12. Background Papers

12.1. There are none.